TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Doctors Hospital at Renaissance

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-16-3579-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
August 1, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount."

Amount in Dispute: $233.70

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual believes the requestor was paid correctly for codes 26418 and 94640. No additional payment is due. Texas Mutual claim (claim number) is a participant in the Texas Star Network and Doctors Hospital at Renaissance had out of network authorization to treat for the date above. (Attachment) Rule 133,305(a)(5) defines a medical fee dispute as one that involves "…an amount of payment for non-network health care…The dispute is resolved by the division pursuant to division rules, including §133.307 of this title (relating to MDR of Fee Disputes)…" Because this is network healthcare Rule 133.307 does not apply. Rather, the requestor should access Complaint Resolution through Coventry Workers' Comp Services."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 27 - 28, 2016	Outpatient Hospital Services	$233.70	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for services provided in

outpatient hospital services.

3. 28 Texas Insurance Code Chapter 1305 applicable to Health Care Certified Networks.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 350 – In accordance with TDI-DWC 134.804. This bill has been identified as a request for reconsideration or appeal
   - 370 – This hospital outpatient allowance was calculated according to the APC rate plus a markup
   - 616 – This code has a status Q APC indicator and is packaged into other APC codes that have been identified by CMS
   - 617 – This item or service is not covered or payable under the Medicare outpatient fee schedule
   - 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
   - 724 – No additional payment after a reconsideration of services
   - 725 – Approved non network provider for Texas Star Network claimant per Rule 1305.153(c)
   - 767 – Paid per O/P FG at 200%. Implants not applicable or separate reimbursement (with cert) not requested per Rule 134.403(g)
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time
   - W3 – In accordance with TDI-DWC Rule 134.804. This bill has been identified as a request for reconsideration or appeal

Issues

1. Is the respondent's position supported?
2. What is the applicable fee pertaining to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent states in their position, "Because this is network healthcare Rule 133.307 does not apply. Rather, the requestor should access Complaint Resolution through Coventry Workers' Comp Services."

   The requestor filed this medical fee dispute to the Division asking for resolution pursuant to 28 Texas Administrative Code (TAC) §133.307 titled *MDR of Fee Disputes*. The authority of the Division of Workers' Compensation is to apply Texas Labor Code statutes and rules, including 28 TAC §133.307, is limited to the conditions outlined in the applicable portions of the Texas Insurance Code (TIC), Chapter 1305. In particular, TIC §1305.153 (c) provides that "Out-of-network providers who provide care as described by Section 1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation."

   Texas Insurance Code Section 1305.006 states,

   > An insurance carrier that establishes or contracts with a network is liable for the following out-of-network health care that is provided to an injured employee:
   >
   > (1) emergency care;
   >
   > (2) health care provided to an injured employee who does not live within the service area of any network established by the insurance carrier or with which the insurance carrier has a contract; and
   >
   > (3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section 1305.103.

Review of the submitted documentation finds that respondent acknowledged network approval via the Explanation of Benefits reason code by stating "725 – Approved non network provider for Texas Star network claimant per Rule 1305.153(c)." The Division finds that the EOB reason 725 is sufficient evidence to support the required referral for out-of-network to treat the injured worker was obtained. For this reason, the services in dispute will be reviewed per the applicable Division Rules and Fee Guidelines.

2. The services in dispute are for outpatient hospital services and are therefore subject to the requirements of 28 Texas Administrative Code 134.403 (d) which states in pertinent part, "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided..." The applicable Medicare payment policy may be found at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS.

   In order to calculate the correct Division fee guideline, stakeholders should be familiar with the main components in the calculation of the Medicare payment for OPPS services which are:

   - **How Payment Rates Are Set**, found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsht.pdf,
     - *To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.*
   - **Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. The relevant status indicator may be found at the following: www.cms.gov, Hospital Outpatient Prospective Payment – Final Rule, OPPS Addenda, Addendum D1.
   - **APC payment groups** - Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. The relevant payment amount for each APC may be found at: www.cms.gov, Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files, Addendum B. These files are updated quarterly.
   - **Medicare Claims Processing Manual, Chapter 4, Section 20 - Reporting Hospital Outpatient Services Using Healthcare Common Procedure Coding System (HCPCS) -** The HCPCS codes are required for all outpatient hospital services unless specifically excepted in manual instructions. This means that codes are required on surgery, radiology, other diagnostic procedures, clinical diagnostic laboratory, durable medical equipment, orthotic-prosthetic devices, take-home surgical dressings, therapies, preventative services, immunosuppressive drugs, other covered drugs, and most other services. When medical and surgical supplies (other than prosthetic and orthotic devices as described in the Medicare Claims Processing Manual, Chapter 20, §10.1) described by HCPCS codes with status indicators other than "H" or "N" are provided incident to a physician's service by a hospital outpatient department, the HCPCS codes for these items should not be reported because these items represent supplies. Claims containing charges for medical and surgical supplies used in providing hospital outpatient services are submitted to the Medicare contractor providing OPPS payment for the services in which they are used. The hospital should include charges associated with these medical and surgical supplies on claims so their costs are incorporated in ratesetting, and payment for the supplies is packaged into payment for the associated procedures under the OPPS in accordance with 42 CFR 419.2(b)(4).

   28 Texas Administrative Code §134.403 (f) states in pertinent part,

   The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and

effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 200 percent;

The service in dispute is calculated as follows:

Submitted code	Status Indicator	APC	Payment Rate	Unadjusted labor amount = APC payment x 60%	Geographically adjusted labor amount = unadjusted labor amount x annual wage index/0.7989	Non labor portion = APC payment rate x 40%	Medicare facility specific reimbursement (geographically adjusted labor) amount + non labor portion)	Maximum Allowable Reimbursement
26418	T	5121	$1,455.26	$1,455.26 x 60% = $873.16	$873.16 x 0.7989 = $697.57	$1,455.26 x 40% = $582.10	$697.57 + $582.10 = $1,279.67	$1,279.67 x 200% = $2,559.34
							Total	$2,559.34

The remaining services in dispute were reviewed as follows:

- Procedure code A6222 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 36415 has Status indicator “Q4” designates packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator “J1,” “J2,” “S,” “T,” “V,” “Q1,” “Q2,” or “Q3.” Review of the medical claim finds code 26418 with a status indicator “T” therefore code 36415 is packaged and no additional payment is recommended
- Procedure code 80048 has Status indicator “Q4” designates packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator “J1,” “J2,” “S,” “T,” “V,” “Q1,” “Q2,” or “Q3.” Review of the medical claim finds code 26418 with a status indicator “T” therefore code 80048 is packaged and no additional payment is recommended
- Procedure code 82962 -91 has Status indicator “Q4” designates packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator “J1,” “J2,” “S,” “T,” “V,” “Q1,” “Q2,” or “Q3.” Review of the medical claim finds code 26418 with a status indicator “T” therefore code 82962 is packaged and no additional payment is recommended
- Procedure code 82962 has Status indicator “Q4” designates packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator “J1,” “J2,” “S,” “T,” “V,” “Q1,” “Q2,” or “Q3.” Review of the medical claim finds code 26418 with a status indicator “T” therefore code 82962 is packaged and no additional payment is recommended
- Procedure code 85027 has Status indicator “Q4” designates packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator “J1,” “J2,” “S,” “T,” “V,” “Q1,” “Q2,” or “Q3.” Review of the medical claim finds code 26418 with a status indicator “T” therefore code 85027 is packaged and no additional payment is recommended
- Procedure code 94640 has status indicator Q1 denoting STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date. Review of the medical claim finds code 26418 with a status indicator “T” therefore code 94640 is packaged and no additional payment is recommended
- Procedure code J2765 has status indicator N denoting packaged items and services with no separate APC payment.

- Procedure code J0690 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J2001 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J1885 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J2405 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J2250 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J3010 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code A9270 has status indicator E denoting non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims. Reimbursement is not recommended.

3. The total allowable reimbursement for the services in dispute is $2,559.34. This amount less the amount previously paid by the insurance carrier of $2,588.50 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		September 20, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.